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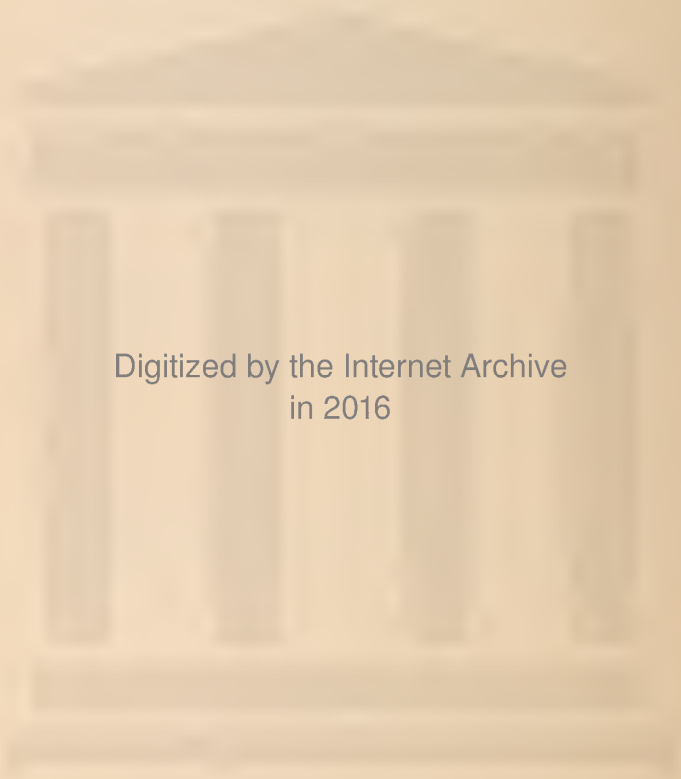

The Fort Logan Mental Health Center is a new state hospital which will eventually serve half of the population of the state of Colorado. Its organization follows as much as possible the recommendations of the Joint Commission on Mental Illness and Health. Concepts of milieu therapy are strongly utilized, with the emphasis on expansion of professional roles and the involvement of the patient's family and his community as much as possible in treatment. The hospital is entirely open and relies heavily on transitional forms of treatment. One-half of its patients are in day care, and evening care is being instituted. Geographic and administrative decentralization are utilized, with the same psychiatric team following the patient through admission, treatment, and outpatient care.

EDITOR'S NOTE

As we begin the second volume of the Journal of the Fort Logan Mental Health Center, we wish to express our appreciation for the many encouraging comments we have received about our first two issues. Over 1000 institutions and professional people in the United States and other countries now receive the Journal, and it has been selected for indexing by Index Medicus and accepted for abstracting by Psychological Abstracts and Sociological Abstracts.

With this issue we are starting a new Letters to the Editor section, for which we invite your continued comments, criticisms and suggestions. In addition, we are most interested in increasing the proportion of contributions to the Journal from sources outside Fort Logan. Accordingly, we would like to extend a warm invitation to all professionals interested in social psychiatry to submit relevant articles, clinical notes, or book reviews. Details of manuscript format are on the inside back cover of the Journal.

P.P.

GENERALIZATION GRADIENTS AND A CONTINUUM OF SOCIAL-PSYCHIATRIC THERAPIES*

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The processes by which animals and men learn has long been an area of experimentation and theorization for psychologists. The results of their investigations began to make an impact on educators at the turn of the century, and this influence has steadily grown. A major and growing interest in the application of learning theory to psychotherapy was initiated at a somewhat later time with the early publications of psychologists such as Watson and Rayner (15) and others, and has continued to the present with the work of Wolpe (17), Eysenck (6), Mowrer (11), and many others. The recent work of Dollard and Miller (5) presents a thorough discussion of the application of learning approaches primarily to analytically oriented outpatient individual psychotherapy.

The aim of the present discussion is to extend Dollard's and Miller's approach into the area of the application of learning approaches to the social-psychiatric treatment of major mental illness. This initial paper will explore the possible contribution of one specific area common to many learning theories, the gradient of generalization, to a model of a continuum of social-psychiatric treatment. Future papers will consider the potential contribution of other facets of learning theory to social-psychiatric treatment.

In broadest rather behavioristically slanted learning terms, hospital treatment of the mentally ill may be described as a process by which unhealthy or inappropriate behavior on the part of the patient is either not reinforced until extinction occurs or negatively

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*The author wishes to express his indebtedness to Dr. John Dollard, whose writings and personal comments have greatly influenced the concepts in this paper.

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reinforced. Healthy behavior is positively reinforced, and the emergence of new healthy responses is facilitated. In addition, the patient is taught new approaches to solving problems of living aimed at continuing his improved adjustment after discharge from the hospital.

The term "gradient of generalization," introduced by Hull (10), forms part of most learning approaches, although the wording and explanation vary with different learning theorists. It is a basic part of such differing learning theory positions as those of Thorndike (14), Pavlov (12), Guthrie (9), and Skinner (13), although they focus on different aspects of the phenomenon and use different terms to describe it. Basically, it describes the transfer of learning under one set of conditions to a similar set of conditions. The more the second set of conditions resembles the first, the more transfer of learning takes place.

Anrep's 1923 study (3) in which he conditioned dogs to salivate to tactile stimulation at specific parts of the body may be taken as an illustration of generalization gradients. He measured the amount of salivation that took place under test conditions in which the same tactile stimulation used in establishing the conditioned learning was given at varying distances from the location of the original unconditioned tactile stimulus. The change in the location of the stimulus still resulted in salivation, but in a lesser amount of salivation than when the original learning situation was exactly repeated. The amount of salivation decreased with increasing distance of the test stimulus from the original conditioned stimulus. The curve that represents such data is diagrammatically represented in Figure 1.

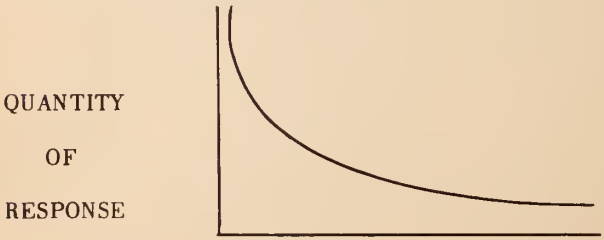

Figure 1. Diagram of gradient of stimulus generalization.

The curve of the diagram is a typical one for generalization gradients. That is, it is concave upwards. Such gradients of stimulus generalization occur in much more complex types of learning than the conditioning example given.

The generalization gradient data of learning theorists have had direct impact on educators for the past half century in the controversy over transfer of training. Experiments, such as those of Thorndike in 1923, which reported that the learning of Latin produced only a slight advantage in the reading of English, have fed the controversy. The problem of transfer of training from what is learned in school to real life situations seems to directly parallel the problem of psychotherapy. Deese (4), for example, says in his general text on education:

> Perhaps the most important single determinant of the amount of transfer that is possible . . . is the knowledge, on the part of the learner, that what he is learning can be transferred. The learner must also be motivated to apply what he has learned to new situations that are similar in character. On the other hand, the teacher can expect little or indifferent transfer when the opportunities for transfer and the need for transfer are not emphasized.

If the word "patient" is substituted for the word "student" and the word "therapist" is substituted for the word "teacher" in the above quotation, it seems strikingly pertinent to the practice of psychotherapy. However, although educators have struggled with the problem for many years, psychiatry appears to have given it scant attention.

With the common practice of psychotherapeutic methods that involve an environment far removed from that of real life, it seems exceedingly curious that there has been so little consideration in the psychiatric literature of the problem of application of what has been learned in the removed environment of the psychotherapy session to real life situations. Thus, Fenichel's text on psychoanalysis (7) has nothing to say on this subject, while Wolberg's eight-hundred-page work on psychotherapy (16) devotes approximately ten pages to a discussion of intervention in the patient's environment and the translation of insight to action.

Although the problem of application of what is learned in psychotherapy to real life has been touched upon or outlined by several authors, none seems to have examined it in great detail.

Freud, speaking of transference phenomena occurring in institutions, wrote, "Actually, it is quite unimportant for his cure whether or not the patient can overcome this or that anxiety or inhibition in the institution; what is of importance, on the contrary, is whether or not he will be free from them in real life." (8) Alexander and French suggest in their text of psychiatry (2) that the psychotherapist should encourage real life trails by "timely directives and encouragement." Alexander goes on to say in his book *Fundamentals of Psychoanalysis* (1):

> The therapist must constantly direct the patient's attention to his outside relationships and not allow him to withdraw completely into the therapeutic situation. It is very important to encourage similar experiences within and outside the analysis at the same time. . . . As the patient changes his neurotic pattern toward the analysis . . . the same behavior should be encouraged toward an employer, a father, or an older brother. . . . Steady pressure must be exerted on the patient to apply every anayltic gain to his life outside the analysis.

Dollard and Miller (5) thoroughly discuss the application of learning generalization to analytically oriented individual psychotherapy. In their book *Personality and Psychotherapy* they discuss transference in psychotherapy as an instance of generalization. Positive and negative attributes are generalized to the psychotherapist from the patient's previous experience with parental figures or their substitutes. Many other types of previous learning, such as the patient's previously learned ability to be self-critical, are generalized to the therapy situation. The process of therapy, using such techniques as labeling, involves the gradual emergence of discrimination in the transference, so that the patient eventually comes to see the therapist as he really is, thus correcting the earlier generalization in the transference.

Dollard and Miller see psychotherapy occurring in a protected situation in which the patient can come to know himself. His emerging neurotic trends need to appear at first in such a protected environment, which obviates the patient's having to suffer the results of acting on neurotic tendencies in the real world. Speaking of repetition and generalization, they state (5):

> After a patient has learned in one situation to label something correctly, such as an aggressive response motivated by anger, he may not immediately generalize the correct label to all other rel-

evant situations. He may have to relearn the label in a number of somewhat similar situations before he has a habit that generalizes readily.

The gradient of generalization would seem to have direct application to the treatment of major mental illness in two areas: first, the generalization of previously learned inhibitions and unhealthy responses to psychotherapy; and, second, the generalization of what is learned in psychotherapy to the patient's real life. Let us examine each of these areas of application in greater detail.

THE GENERALIZATION OF PREVIOUS UNHEALTHY LEARNING TO THE THERAPEUTIC SITUATION

For the patient to unlearn inappropriate behavior patterns, either these patterns or their verbal representatives must first appear in the therapeutic situation. If this is true, it implies that a single therapist can provide the vehicle for the patient for only a limited number of generalizations, which are based on factors such as the therapist's sex, personality characteristics, and physical features. Factors, such as the degree of similarity of the socioeconomic level of the treatment environment to the environment in which the patient lives, will influence the degree to which generalization of the real problem behavior of the patient to the therapeutic setting will take place. This would suggest that an ideal therapeutic environment have variegated characteristics, to which the differing problems of different patients might be successfully generalized. Moreover, a team of therapists would seem to offer advantages over the team of one. The patient with problems relating to authority figures might clearly generalize his problem behavior in relating to a warmly aggressive team member and be able to discuss and gain insight into his behavior most profitably with a less active team member. Not until the pathological behavior is generalized to the therapy situation can it be unlearned and the emergence of new responses be encouraged to take its place.

At this point, a second, and perhaps more crucial, aspect of the generalization of unhealthy previous learning to the thera-

peutic situation should be discussed. Although the environment must provide similar enough cue situations for the pathological behavior to generalize to it, it should also provide stimulus situations far enough removed from the original inhibiting situation that new healthier responses can successfully emerge. The previously mentioned patient with problems in relating to authority figures may have extreme difficulty in learning appropriate expressions of anger. In fact, he may have none at all at his disposal. To express anger to his boss at work might be unthinkable, since the inhibition originally learned in relation to the father might generalize too greatly to the situation with the the boss, which strongly resembles it. However, he may find it possible to take his first steps in the direction of appropriate expression of anger in a relatively far-removed protective environment, such as that provided by individual psychotherapy or group therapy.

In summary, a consideration of generalization gradients would suggest that the optimal therapeutic environment be sufficiently diverse to resemble the patient's environment enough that his problem behavior generalizes readily to it and yet have facets far enough removed on the gradient of generalization that initial, healthier responses may emerge.

THE GENERALIZATION OF WHAT IS LEARNED IN PSYCHOTHERAPY TO REAL LIFE

The characteristic curve of the gradient of generalization is a steep one. That is, a new situation need only be slightly removed from the original learning situation for little transfer of learning to take place. Thorndike's early findings that the learning of Latin helped little in the reading of English created a great controversy amongst educators, which has not yet been resolved. Unfortunately, there has been no parallel study of psychotherapy. In spite of the widely held belief of psychiatrists that insights gained during psychotherapy will result in marked changes in behavior, new learning that takes place in a

psychotherapeutic setting far removed from real life may generalize very little to real life situations. The application of what is learned in most psychotherapeutic settings to situations outside therapy is today left primarily to the patient. The therapist has little control of the patient's initial applications of what he has learned to his real life situation. The patient who first learns to express anger in therapy may, by chance, express anger to a person having greater problems with anger than the patient, with dire consequences for treatment. The laws of generalization of learning would suggest greater use of semistructured situations in which initial learning could be tested over which the therapist has some control. Such settings for initial learning could be provided by the semisheltered environment of group therapy, for example, or a patient activity on a psychiatric ward in which the therapist is involved. As learning progresses, it could take place in settings which gradually approach real life and with the therapist eventually participating in the patient's family, community, and work life.

With the suggestions made by the application of the gradient of generalization to psychotherapy thus far, let us examine the attributes of a possible ideal therapeutic setting. Such a setting should have many different properties. It should bave characteristics close enough to the initial environment under which the inappropriate behavior was learned for generalization of the behavior to take place and, at the same time, have situations far enough removed from the original unhealthy learning that the emergence of new healthy responses is possible. Finally, the location of therapy would gradually move forward to settings as close as possible to real life, so that optimal transfer of what is learned in psychotherapy to real life may take place.

Such requirements could be met in a hospital setting with a team of different therapists and with a multifaceted program so organized that the patient could systematically undergo therapeutic learning under a wide spectrum of conditions, from those far removed from real life situations to those closely resembling them. An individual plan could be made for each patient, depending on his specific needs. However, it would be logical to expect

greater use of more artificial and protected settings in which new healthy responses could gradually emerge in the initial phases of treatment. Formal individual psychotherapy would provide such a setting, as would certain types of group therapy. As learning progresses, the patient would be given increasing opportunity to apply his new learning to therapeutically controlled situations that are closer to real life. Role playing and psychodrama provide such opportunities, without being so close to the original inhibiting learning situation to prevent the further development of the new responses. In addition, if a milieu therapy approach is used, the patient would be expected to interact increasingly with other patients. This interaction would give him more opportunity to test what he has learned in a semicontrolled setting. If the staff is involved in real life interaction with patients, further learning occurs closer to the real life situation, and greater probability of generalization of what is learned exists. At some point in this continuum the people with whom the patient relates in real life would actually be brought into the therapy situation. Relatives, and other people significant to the patient who have been encouraged to maintain contact with the hospital and the patient from the onset of his treatment, may at this point participate in joint therapeutic activities in which the patient and his therapist are involved. These could take for example, the form of "family therapy" at the hospital or of the therapist's involvement in various living activities at the hospital to which the patient's relatives or friends have been invited.

Finally, for optimal generalization of psychotherapeutic learning to real life to take place, the therapist should involve himself in the living interactions of the patient, not in the environment of the hospital, but in the environment in which the patient lives. The last stages of therapy, then, would take place, whenever practical, in the patient's home or at his place of work or in his community and would involve the people with whom he interacts in these settings.

The beginning point of each patient on this gradation of therapeutic settings and the rate of progress made would depend on the particular problems and needs of the individual patient. The therapists in such a program could plan with each patient his

specific rate of progression along such generalization gradients. They would need to be flexible enough to adopt the changing roles demanded of them as the patient progresses.

It should be made clear that such a therapeutic program suggests neither that the major part of the psychotherapy take place in the therapist's office in the form of individual psychotherapy nor that the bulk of treatment occur in the patient's home or job. It does suggest a well balanced, individualized schedule of various types of therapeutic activities in which the patient progresses from types of therapy far removed from real life, where new responses may emerge, through therapies closer to real life, where the new responses are strengthened, finally to situations close to, and including, real life situations.

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PARTICIPANT OBSERVATIONS ON PATIENT CULTURE IN A THERAPEUTIC-MILIEU SETTING

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The world in which a patient finds himself in any mental health facility is, like any social world, certainly sufficiently complex and transitory to defy complete characterization or description. Caudill's *The Mental Hospital as a Small Society* (1) and Goffman's *Asylums* (2) stand as substantial contributions towards this end. The material of this paper is derived from a participant observation experience, which took place at the Fort Logan Mental Health Center during the summer of 1963, when the author lived on one ward as a 24-hour patient for eight consecutive days. The author's purpose is to describe his observations of patient culture on one ward. No hard-and-fast conclusions about the ward or generalizations about all of Fort Logan, which contains several treatment groups of considerably differing practices, are meant to be drawn.

I had been visiting Fort Logan during the previous year on a one-day-a-week basis and had participated in several of the treatment program activities. My participation as an outsider in the formal scheduled activities had given me little inside information on the informal activities. I had rehashed experiences with staff, but not with patients. I had seen isolated events, but not in their situational framework or natural flow. Having come to feel that my understanding of actual milieu therapy was severely limited, I hoped to deepen my understanding of the ward culture by participating in it as a patient.

I intended to make naturalistic and descriptive observations. My approach to being a patient observer, as I saw it prior to entering

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Fort Logan, included the belief that I was going to learn something new and the decision that I was not going to question the rightness or wrongness of the patient group into which I was going. In this new situation I would be a student, and the other more experienced patients would be my teachers. I was willing to accept a definite degree of authority of the other patients over me. I wanted to be a "good patient," as defined by patients. The basic question I carried with me was, "What is it like to be a patient in their world?"

My previous visits to the center had identified me to both patients and staff as a sociologist interested in learning something about patient life. Prior to my being admitted as a patient, both staff and patients agreed that on entering the center I would be treated as a patient, subject to all the rules and regulations of the other patients. Nevertheless, I could not always be treated like any other patient. It was my impression that in time patients came to accept me *more* fully in the role of patient than staff. My relationships on the ward were generally more with interactive patients in the age group from teens to mid-thirties than with other patients.

THE THERAPEUTIC TEAM

While I had had the idea that the term "team" at Fort Logan referred to the combined patient-staff group on a given ward, I soon noted that it could refer to staff or patients or both patients and staff. It was necessary to rely on context to determine which meaning was being used, whether by a patient or a staff member. The ambiguity in the use of the idea "team" suggests that patients consider themselves to be a team within a team. That both patients and staff selectively invoke one of these three meanings raises questions as to how the selected meaning functions in different situations.

To illustrate one situational function of this term, a particular patient was told one day in group therapy that although he often voiced his opinions about the problems of others, he never really brought out his own problems. It was suggested that in

order to get personal benefit from the group session, he talk more about his own problems. Afterwards as some patients were having their own informal rehash, this patient was grumbling about the staff being pushy and overly anxious to get patients out of the institution. Another patient agreed with him right down the line and then went on to suggest that it *would* be worthwhile if he would open up more in group. In this case, the patient giving advice first disavowed identification with the larger group of staff and patients represented by group therapy and then identified himself with the patient group in order to gain a hearing with the advised patient.

The line which the patient thus must tread might seem a narrow one, but there are some definite mechanisms which he can use to protect his position. A young girl who was a patient leader on the ward was very often active in getting set goals carried out. However, on occasion she would organize patients in a kind of recreational activity called "giving the staff hell," singling out a particular staff member for harassment. One function of this behavior was her affirmation of solidarity with the patients. She purposely selected a staff member who responded to her behavior as if it were an expression of her illness and allowed the other patients to share in this deception.

The rule which seems to operate in these examples is that patients can function therapeutically as long as they take care to demonstrate that they are not identifying with, or "playing," staff. I often heard a patient grumble about some fellow patient "beginning to act like he was a staff member." The implication was that this showed he was "getting too smart" and "should be brought back into line."

COTTAGE ECOLOGY

If the patients constitute a team within a team, then one would expect that they would carve out a kind of home territory for themselves within the life space of the cottage which they share with the staff. I first had the reality of this suggested to me by a patient in the course of a conversation in the day room one

evening. As the conversation was taking a rather personal turn, he suggested that we move across to the opposite (east) side of the room, although there did not happen to be a staff member in sight. I inquired why, and he replied, "Over there we won't be disturbed."

During the days that followed, I noted that on the east side of the day room I never found staff members passing the time of day or just "hanging around." On the west side of the room there were two card tables and behind them a long, low cabinet upon which several persons could sit. This grouping was located exactly halfway between and a few steps away from the nursing station and the cottage kitchen, where coffee and milk were available. This west side of the day room was a nucleus of patient-staff interaction, and staff members would pass their time there. To move across the room to the east side was essentially to move out of an area of high patient-staff activity to the periphery and into an area of increased privacy. I often saw a patient sitting alone on the east side and a staff member then going over to talk with him, but never a staff member sitting alone on the east side and a patient going to him. The latter was, however, a common occurrence on the west side. This suggests that the east side of the day room is patient territory wherein the staff member is visitor, while the west side is shared patient-staff territory. Naturally, the staff has its own home territory in the glassed-off nurse's station which is *formally* off limits to the patients. The convention of the patient territory on the east side of the day room, while informal, is effective.

PATIENT-TO-PATIENT RESPONSIBILITY

The notion of patient-to-patient responsibility would seem to be closely linked with that of patient-to-patient solidarity, or what might be called the feeling of "being in the same boat together." One morning a patient whom I happened to know particularly well remained in bed, although several other patients had tried to rouse him out. Just before it was time for all of us to go to breakfast, I went to his room and announced that as far as I was concerned, it was just fine if he stayed in bed. The staff could well see that we had done our best to get him up, and so, if he did not, it would be

his head and not ours. He boldly replied, "That's what you think; it doesn't work that way around here. Anytime they want to slap on a group restriction, they will." I later asked patients if this were so and found his judgment corroborated.

Before I became a patient, I had known about the rule whereby group restrictions could be imposed for individual infractions. Especially at the beginning of my stay, the existence of this rule assisted me in getting the patients to instruct me in the "do's" and "don'ts" for patients and what I generally needed to know in order to get along. As I was still an outsider, they demanded a rationale for my questions; and I explained that if I didn't know what was expected of me as a patient, I might well break rules out of sheer ignorance, which could get us all put on restrictions. Since that would mean that I really was to be dealt with like any other patient, the patients were at first clearly skeptical. A patient of considerable influence then asked the team psychiatrist if this was true and got an unequivocal yes. This was the first decisive step in putting me into the "patients' boat." After that I was taken into tutelage, without my having to ask anymore. Later, when I told some close fellow patients that I wasn't so compulsive that I wanted to follow all the rules all the time, they instructed me in methods of getting around rules without getting caught.

Here, then, is a case where staff policy establishing possible group restrictions for individual infractions fosters patient solidarity and patient-to-patient responsibility. It is directly in the self-interest of the patients to educate new patients and to be concerned with their participation in the program. Further, the implicit understanding seems to exist among patients that to expect total conformity is unrealistic. The patients, then, have an additional direct interest in controlling the degree of necessary or natural patient deviation. In other words, a patient has a self-interest in keeping a degree of control over both the conformity *and* the deviation of the other patients.

TRANSLATION OF STAFF DOGMA INTO PATIENT CULTURE

The above discussion illustrates how the imposition of group restrictions for individual infractions fosters patients' taking

a self-interest in the social control of the actions of fellow patients. This can be termed the negative reason for the patients' concern for getting other patients to participate in the program, since it aims at minimizing deprivation, i.e., group restrictions. There is also a positive reason which I heard patients express and use in trying to get a recalcitrant patient to go to an activity which he had intended to cut. The argument used, put briefly, went something like this: "I need to get you to go for my good, and you need to get me to go for your good." It was a bit of a surprise to find patients using this staff dogma in persuading fellow patients. On this team the staff consistently pointed up how poor attendance coincided with poor group spirit, and patients are very sensitive to the spirit of activities. Of course, the staff knows only too well that the spirit of group meetings involves much more than attendance. However, in this case the staff simplified their dogma and got good translation into patient dogma. One might well expect that, had they stated all their ideas of what influences group spirit, staff dogma might not have become translated at all into patient usage.

PATIENT INITIATIVE

The following experience illustrates both patient initiative and interdependency. While I was having lunch with two other patients and a nurse, one of the patients said to the nurse, "You know that new patient, the old one? I wish you could do something for her, I mean get her a new dress and a hairdo or something. She's really in bad shape. I'd like to do something for her, but I can't. She's just repulsive. Christ, yesterday I had to sit next to her in group therapy and I thought I'd vomit! I mean she could really use help, and if you could get her fixed up a little bit, then maybe we could do something, but right now she smells and looks too repulsive to get close to." The nurse agreed that this was a good suggestion and promised to get her "fixed up," which she did. Two days later, the elderly female patient, with a new dress and hairdo, found herself in patient tutelage. In this case, it would be difficult to decide who got more help, the patient who initiated the help or the patient towards whom the help

was directed. Here the patient who initiated some staff assistance for a fellow patient was rewarded on a verbal level by the nurse who accepted the suggestion as a good idea and on a behavioral level when this was actually carried out. As fellow patients later remarked how much better the elderly patient looked, the initiator had occasion to point out his part in the improvement.

No matter where a given patient finds himself in the milieu, there is always someone less sick and someone sicker than he. There are, therefore, those he can help and those who can help him. His progress towards release is a kind of zigzag, in which he can get assistance from someone less sick and can consolidate his progress by turning around and giving assistance over the distance that he has recently traversed to someone sicker. Both for extending oneself and consolidating oneself, there are therefore "workable projects" in the form of fellow patients always near at hand.

QUALITIES OF MILIEU THERAPY

The patients' picture of the character of the milieu ethos was expressed to me by a day patient who had spent two months in an insight-oriented individual psychotherapy clinic before being transferred to Fort Logan, where he had to date spent just about the same amount of time. As the conversation worked its way around to his evaluation of the two therapy settings, I asked him in what ways he felt that the Fort Logan setting was distinctive. His reply involved, in sum, three qualitative aspects which he felt made Fort Logan different. First, there is not so much concern with why one came to have a problem as with how to deal with the problem which one has. In his words, "At the clinic you learn why you hate your grandmother, but you are not necessarily any better able to deal with daily problems. At Fort Loganyou learn to deal with these problems and may never get to the grandmother." Secondly, this patient felt that the Fort Logan setting demanded much more initiative of patients. As he put it, "You're expected to put out more to get in on the kind of therapy they have going." Finally, he suggested that the Fort Logan setting was distinctive in that, "There is much more concern here for us taking an interest

in the other patients.

Later I had occasion to inquire of other patients whether they felt that these qualities were reasonable characteristics of their environment and in all cases found them corroborated. In short, the above characterization fit well with common-sense ideas in patient culture.

STAGES IN GETTING THROUGH THE MILIEU

Watching patients operate in the milieu setting, I was able to see distinct stages through which they passed in the course of their treatment. Most apparent is the distinction between the practice stage and the performance stage in patient behavior. Airing a problem with another patient or with a staff member represents an instance of practicing, and, in the same example, presenting that problem in the formal social setting of group therapy is an instance of performing.

During my week on the team, I often saw a form of practice which I came to call "work-up." In this first stage of practicing it was typical for a patient to air a matter of concern in private with another patient or staff member. Here the patient initiated a reality-testing dialogue in the third person; e.g., "What would you think if one were to. . .?" The patient's intent was to check out responses of the other person without committing himself personally and to informally explore how he could eventually bring something out into the open in a more formal setting. I could often see a given patient "work-up" the matter of concern to him with several different patients and staff members. In a sense, it can be said that he was proceeding as a good social scientist, taking a sample of the reactions before assessing how it was going to go.

Given a successful "work-up," that is, a response trend which indicated that his problem was within a legitmate universe of discourse and was not taboo, the patient often moved to a step which I call the "dry-run." In this step he adopted the first person in his presentation. At this stage, the other person could react not just in hypothetical terms of something being done by *someone*, but also in terms of *his* doing something. Here again the patient often tried out with several persons. Being on the ward 24 hours

a day made it possible for me to often hear something brought up in a group therapy (performance) which I had heard "worked-up" and "dry-run" several times on previous days. I found that around 9 p.m. was a time of especially intensive discussion among patients, and was struck by the degree to which personal problems dominated the discourse, with such topics as weather and sports coming in a very late second. I viewed this intensive atmosphere in the Fort Logan setting as concrete evidence of patient-manifested orientation towards practicing behavior.

I would suggest that group therapy is the performance stage in the milieu-therapy setting. Patient initiative and individual effort is essential to the intensive "working-up" and "dry-running" which occurs at various times and locations during the day in the therapeutic milieu. Group therapy appears to be the end towards which the crucial practice is directed. In group therapy recognition, certification, and reward are conferred. Patients generally believe that in order to be discharged from the center, they have to bring up their problem in group and demonstrate that they are "on top of it." The rites of passage are performed on the stage of group therapy. Knowing this, the patient is faced with the task of preparing himself for these rites. This preparation occurs on the informal practice field, where the scheduling of activities is largely the result of individual patient choices. Thus, when a patient picks a fellow patient or staff member with whom to air a problem, he is essentially scheduling an informal but vital part of his treatment program. This is rarely the perception of the patient in treatment, but that does not negate the import of his acts. As a parallel, university students claim that their classes are most important in their development, but when polled a few years after graduation claim informal associations as having been most important for their development during college. Whether or not a patient perceives his pattern or informal associations as self-scheduled treatment program is perhaps not important. It is important, however, that the structure of the situation in which he finds himself promotes informal associations which have positive therapeutic content.

CONCLUSION

This paper has attempted to present some anecdotal accounts of participant observations made while I was a 24-hour patient for eight days on a team at the Fort Logan Mental Health Center. These selected observations cannot be considered systematically representative, but rather only suggestive of patient culture on that team during the summer of 1963. Although I have referred to the Fort Logan setting in the body of the paper, there is no empirical basis for generalities being drawn about other teams. This is a necessary restriction in relation to Fort Logan, where considerable autonomy is granted the various psychiatric teams and where their individual *versuchsfreudigkeit* (joyful experimentation) is a hallmark.

The most important conclusion gained from my participant observation experience is that a paradigm for apprehending a given milieu-therapy setting *as it exists* must involve not only stated ideals, accounts of occurrences, and actual doings of staff members, but also the patient dimension in all these three aspects. Just because patients and staff are interacting, we cannot *assume* that patient-stated ideals and staff-stated ideals in regard to the treatment program are the same. The degree to which there is a positive correspondence between the two might be taken as a partial indicator of the success of the treatment program, but this demands systematic empirical study.

A valid representation of a therapeutic milieu setting will require a reapportionment which takes both the staff and patient dimensions into account.

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A SIMPLE TECHNIQUE FOR RECORDING GROUP PROCESS*

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Effective up-to-the-minute communication among staff members on a psychiatric ward is essential. With the increased emphasis on group psychotherapy in a milieu setting, such communication becomes more complex. In addition to nurses' and attendants' notes on individual patients, there is now a need for recording group process.

RECORDING TECHNIQUE

To meet this need, a treatment ward at the Colorado Psychopathic Hospital developed a form for recording group process aimed at providing meaningful information and, at the same time, requiring a minimum of time to fill out. The form was used to record daily group sessions, as well as occasional psychodrama groups and evening patient discussions. The recording itself was done immediately following a group session by a nurse or attendent and required five minutes or less to complete. The form is presented in Figure 1. It is divided into two parts, one describing group process and the other describing individual patients. All items can be completed by checking, except for the theme, which requires a short written description. At the Colorado Psychopathic Hospital, the ward clerk was responsible for mimeographing forms and for typing names of the individual patients on the form

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*I would like to acknowledge the help of Elizabeth Hassler, R. N. and of the nurses, attendants, and residents of the South II Ward of the Colorado Psychopathic Hospital. Without their encouragement, this technique would not have been devised.

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each day. After being completed, the group therapy forms were kept in a looseleaf notebook in the nursing station so that they could be available to any of the staff at any time.

In rating affects, it was decided to limit our main consideration to verbal expressions. Inferred affect states, such as bound anxiety and affect equivalents, were not taken into account in our ratings. However, judgments of affects were not based merely upon the superficial content of the verbal communications. It was considered important to use psychiatric skills in evaluation, taking note of behavior such as double talk, metaphors, tone of voice,

DATE_____ RECORDER _____

I. PROCESS

A. SUSTAINED AFFECTS

	Minimal	Mild	Moderate	Strong	Very Strong
1. DEPRESSION	1	2	3	4	5
2. ANXIETY	1	2	3	4	5
3. ANGER	1	2	3	4	5
4. SHAME OR GUILT	1	2	3	4	5
5. OTHER _____	1	2	3	4	5

B. MAJOR THEME(S)

II. INDIVIDUAL PATIENTS (Consider verbal communication only.)

PATIENT	RATINGS									
	Passive-active					Inappropriate-appropriate				
	Very P 1	Mod. P 2	Mildly A 3	Mod. A 4	Very A 5	Mostly Ina. 1	Mod. Ina. 2	Mildly Ina. 3	Mostly Ap. 4	Entirely Ap. 5
Jones										
Brown										
etc.										

Figure 1. Group process form.

and defensive talking. A group might be rated strong in anger, for example, although members had verbally denied that they felt angry. In spite of these apparent complexities in rating affects, independent agreement was achieved (see below). Individual patients were rated *only* in regard to verbal communication. Thus, the passive-active dimension is equivalent to the amount of verbal interaction.

USEFULNESS OF RECORDING

We have found the form useful both in communicating and in learning about group process. It provided quick reference to group-therapy meetings that one could not attend. Frequently a shift of nurses and attendents coming on duty could get an idea of the "feeling tone" of the ward community from the recordings. The "Individual Patients" section proved helpful to the therapist in evaluating the progress of a single patient. At a glance, he could see how his patient performed in the group on a certain day of a specific week. He might discover, for example, that his patient was relatively inactive and inappropriate whenever the sustained affect of the group was anger.

Happily, a by-product of the recording technique was its educational value. By forcing the recorder to make judgments, it encouraged thought and often precipitated discussions about group process or ward milieu, either at the time of the recording or when someone else read the form later. Such discussions sharpened the ability of the staff to think more clearly and to communicate more effectively.

RESEARCH POSSIBILITIES

While its primary purpose was a utilitarian one, the group recordings also provided a means of collecting data for research.

In order to gain an estimate of the reliability of the technique, a nurse and an attendant each independently recorded group process on four different days. Inter-rater percentage agreement was then calculated on all items which were rated. The "Major Themes"

section of the form could not be included in this study, since it is an open-ended item. Of a total of 83 rated items, the two recorders reached agreement within one rating on 79, for a percentage-agreement-within-one of 95%. On two of these days, another nurse also independently rated group process and the percentage-agreement-within-one among the three was 86%. While based only on a small sample of observations, it was felt that these figures lend support to the notion that nurses and attendants can agree readily using this form.

Intriguing research possibilities arose from the fact that patterns of interaction of patients in group therapy could easily be studied in retrospect.

In an attempt to examine such longitudinal data systematically, 14 patients were chosen for study. These patients represented all those admitted over an arbitrary six-week period who remained hospitalized for a period of two weeks or longer. Individual graphs were constructed for each patient, with hospital days plotted against the 1-to-5 rating scale so that activity and appropriateness curves could be drawn in each case. In addition, group-sustained affects were represented along some of the curves.

Some interesting patterns appeared, although one must use caution in generalizing from such a small number of patients. An initial pattern of high activity and marked inappropriateness was seen in four patients. Such a pattern disappeared in all during the first week of hospitalization. No patients were able to maintain a pattern similar to this at any time later in their hospital stay. A tempting interpretation of these data is that they show the constant group pressure pushing toward appropriateness. The active individual who is inappropriate is apt to feel the pressure the most; in fact, only on admission when an individual is not yet accepted into the group is he able to maintain this pattern over several days.

A rather surprising impression gleaned from the data was that the group-sustained affects do not seem to influence the in-individual curves of activity or appropriateness in any systematic way. In fact, the consistency of the curves of individual patients, when viewed longitudinally, was striking. A pattern of interaction for each individual was clearly seen from group to

group--whether it was held in the morning, in the evening, or was a psychodrama group. An example was a hypomanic patient, who, initially after coming into the hospital, was rated high in activity and low in appropriateness, and who gradually became more appropriate and inactive. The curve describing her group behavior was relatively unvaried. Of four patients with the diagnosis of character disorder included in the sample, two tended to be high in activity and appropriateness throughout their stay, while the other two were relatively high in appropriateness but were extremely variable as to activity while in the hospital. Again, however, each individual's pattern appeared distinct and persistent. It was as if for each individual patient a profile was established which was striking for its patterned appearance, rather than being haphazard. One might speculate that a patient's character structure and psychopathology were the major determinants of his verbal interaction pattern in the group. The number of days he had been in the hospital, including his proximity to admission or discharge, could influence this pattern, but group affects were less important in causing it to vary.

Whether patterns of group behavior can be classified according to diagnosis or prognosis cannot be stated at this time, but this might be a direction of future research. It is certainly hoped that if this technique of recording is adopted by others, the researcher, as well as the clinician, can benefit.

PATIENT PARTICIPATION IN MORNING REPORTS

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On the D-3 Team at the Fort Logan Mental Health Center, morning report initially consisted of a meeting of the two treatment teams sharing the evening and night coverage of their cottage. During this morning report a member of the nursing staff described the significant events involving the 24-hour patients during the evening and night. On Monday mornings the report covered events of the preceding weekend. After the meeting the two teams separated to follow their own schedules. In the case of the D-3 Team most of the staff members informally gathered in the nursing station after the morning report. Actual patient contact usually did not take place until about an hour after the day staff assembled each morning.

We felt this system had several disadvantages. One was that there were gaps in reporting significant events. A second was that for approximately an hour each morning staff members were inaccessible to patients behind the glass walls of the nursing station.

We were searching for a way to emphasize to the 24-hour patients the importance of their hospital community interactions after the formal treatment program of the day was finished. We wanted to learn what relevant psychiatric events of the evenings, nights, and weekends were not being communicated in morning report. Finally, we thought it would be useful to discuss openly with the patients each morning any distortions or areas of irrational behavior that had occurred the night before.

For these reasons we broadened the morning meeting to

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include a report given by each 24-hour patient on his own behavior and feelings. Following the interteam morning report, all of the 24-hour patients attended a 15-minute report period. We asked each patient to tell this group of eight staff members and nine to fourteen patients how he spent his time the preceding evening or weekend. Whenever possible, we gave prompt, concise answers to questions patients asked in this period, but if time did not permit an immediate answer, we referred him to the appropriate group meeting or team resource. Following the patient report period, the team staff met for half an hour, dealing with the material that came up in both morning reports and other pertinent matters.

In the beginning of this new style of reporting, the team leader took the initiative in asking each patient questions about his activities the night before, and in limiting the amount of discussion on each topic. After a few days, as the group gained knowledge about the manner in which the morning report could be handled, the team leader asked other team members to conduct the report for that day. At the end of two to three weeks, different members of the staff were questioning the patients each morning, thus providing more group interaction about the material under discussion.

As a result of our experience, we discovered that members of the nursing staff often gave morning reports which differed significantly from the patient's account. Usually the discrepancy originated in the way the patient perceived his behavior and we frequently found that as patients improved, they saw their actions as more closely coinciding with those reported by the staff. Infrequently a staff member's subjective evaluation of the previous night was distorted, but the report technique gave the whole group an opportunity to discuss the distortion at first hand. If, for instance, the staff reported the patient had been highly disturbed, we examined this in the patient's presence, which gave everyone a chance to present his view of the behavior in question.

In addition, we found that less striking events, or events that had upset the patient but had not been communicated to the staff and other patients, might be omitted from the staff report but included in the patient report. That is, the staff report might focus on events such as patients going to bed extremely early or extremely late, while the patient report might focus on events such as

visits from relatives or important phone calls. The patient morning report not only provided a valuable means of testing patients' inconsistencies and denials, but also provided the staff with a chance to confront patients with their misperceptions. In addition, it gave the staff a chance to reward rational reporting and lack of distortion.

The hour which included the two 15-minute reports and the half-hour staff meeting was a strenuous one; however, it effectively coordinated and set the tone for the balance of the day's activities. It was often difficult to limit the report periods to 15 minutes, and the leader sometimes had to reassume an active role to achieve this end. Limiting reports was difficult because staff members often felt they should interrupt patients, but were tempted to sit back and do little. This inactivity occasionally forced the team leader to take over directing the meeting again.

After approximately three months, we asked patients and staff what they thought of the new technique. The consenus was that it was useful and, for the most part, had achieved its objectives. The patients seemed to appreciate the increased opportunity to meet with staff members. They felt that the meeting helped to work out some of the community living problems that were constantly arising. In addition, the continuity between daytime and evening activities established by the morning report provided evidence to the patients that staff members regard all these activities as important parts of treatment. Similarly, having to report on their activity during weekend passes emphasized to the patients the importance to therapy of their behavior outside the hospital. We found also that the patient report strengthened and facilitated interaction between day and evening staff. Finally, the expectation of having to report on their evening activities and problems helped make the patients more aware of the meaning of their behavior and resulted in their gaining more insight into themselves.

There were, of course, some objections to the technique. Some patients felt that the expressed purpose of patient reporting was hypocritical--if we had heard reports from the staff, why did we also need to hear from the patients? Others complained that it tended to put patients on the spot too much. Despite these criticisms, however, we felt that both patients and staff regarded the

new kind of morning meeting as an improvement in the program, and one which enhanced team operation and performance.

INTERJUDGE RELIABILITY OF MENTAL-STATUS JUDGMENTS*

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Because the clinical judgments routinely made on mental-status examinations often form the basis of treatment planning, the study of the reliability of these judgments is an important area of concern for clinical research. The Fort Logan mental-status examination consists of a standard set of clinical judgments concerning the patient's perception, intellection, emotions, behavior areas of conflict, relation to reality, diagnosis, and prognosis. Since the recording of these clinical judgments is facilitated through the use of rating scales and check lists, the Mental Status Form readily lends itself to studies such as interjudge reliability estimates.

An interjudge reliability estimate has value as an indicator of agreement among clinicians and as an indirect indicator of the degree to which a clinical instrument fosters agreement among clinicians. If an interjudge reliability estimate is low, one would not place much faith in the instrument as an indicator of the patient's actual behavior, and validity studies employing the mental status would be of questionable value.

In pilot work studying this area, three patients were presented in successive meetings of a group of staff members at the center.

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Each patient was interviewed by a clinician for twenty to thirty minutes. Following the interview, approximately ten minutes was allowed for the observers to question the patient. Next, the interviewer and each observer independently evaluated the patient, using the Fort Logan Mental Status Form. These patients were not necessarily clear-cut examples of diagnostic categories. The over-all diagnoses assigned by the judges to our first case included neurotic, involutional, and reactive depression. With the second case there was complete agreement about the patient having a passive-aggressive personality, with three judges adding "aggressive type." Our third case was variously diagnosed as chronic brain syndrome, passive-aggressive personality with an organic factor, and schizophrenic reaction, paranoid type. Since our cases were not clear examples of various diagnostic categories, one would expect estimates of the level of agreement among judgments made about the specific psychological characteristics would be conservative.

The first case was independently rated by two sets of judges, five in each set. The first set consisted of two psychologists and three psychiatrists from the Fort Logan clinical staff. The second set consisted of one psychologist, one research social worker, a research psychiatrist, and two visiting psychiatrists from another institution. The second and third cases were each evaluated by five or more members of the Fort Logan staff, all of whom were members of the clinical staff except for one research psychologist.

Clinical judgments made across 55 items on the Mental Status Form for each of the three patients form the basis for the present study. These 55 items represent approximately one-half of the items on the Mental Status Form. Each of the 55 items has four possible alternative responses. For example, with the item "recent memory disturbances," the clinican is asked to check whether it is not significant, moderate, or severe, or he may leave the item blank. On "diagnosis" the clinician is asked to indicate whether each of the assigned diagnoses is mild, moderate, or severe, or again he may leave the item blank. Under "areas of conflict," the clinician is asked, among other things, to check whether the presence of each of the defense mechanisms is not

significant, moderate, severe, or not known.*

The nonparametric test used to estimate interjudge reliability was developed by Cartwright (1). This test reflects the number of agreements among the judges and not how closely they agree. With the first case, the mixed personnel achieved a significant level of reliability with $p<.05$, and the reliability of the clinical staff group was significant at $p<.10$ level. In both the second and third cases, the reliability estimates were significant at $p<.10$ level.

In order to obtain significance at the $p<.05$ level with the Cartwright statistical test, on the average only one judge out of five can deviate from the identical ratings of the other four judges. These initial pilot findings suggest a reasonable level of agreement among the judges using the Mental Status Form and point to the possibliity that the items on the Mental Status Form are being understood in much the same way by the judges. They indicate the advisability of future validity studies with the Fort Logan Mental Status Form, as well as additional reliability studies.

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*The reason for selecting only these items with four alternatives was that these data could be conveniently analyzed. In addition, items with four alternatives are the most frequent and commonly used type on the Mental Status Form.

HOME ARTS PROGRAM

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A Home Arts Section has been planned and initiated at the Fort Logan Mental Health Center. The broad therapeutic goals of the program are: (a) to provide an opportunity for patients to learn or relearn homemaking skills; (b) to provide patients with experience in working cooperatively in a basic social situation having daily significance for themselves and their families; and (c) to help patients gain self-confidence through successes gained in homemaking.

The patients in the home arts program are referred by their psychiatric teams. With some exceptions, they attend one day a week for an 8-to-12-week period, depending on their needs and progress. They attend in groups of not more than six patients at a time. In each session, consisting of a four-hour period from 9 a.m. to 1 p.m., the group prepares, cooks, serves, eats, and cleans up after a simple, well-balanced, family-style meal. With the kitchen equipment arranged in two areas, two groups are able to work simultaneously.

The groups are under the supervision of a therapist, who is assisted by a woman volunteer. The therapist (the author) is a homemaker and mother, with whom the women patients can identify. She has a teaching background and has worked on the staff at the Fort Logan Mental Health Center as a mental health technician for a year and a half. The therapist observes the patients' interaction, behavior problems, and progress while working with them in a pleasant mealtime or shopping situation. She is responsible to the respective treatment teams and provides progress reports either by recording observations on the patient's chart or by discussing the patient with a team-assigned liaison person.

This program was planned to foster interchange of ideas

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among the participants about homemaking problems and situations. Patients and staff work together in planning and preparing meals. Each patient is issued a looseleaf notebook. The menus for each day, planned a week in advance, are written on a form which provides space for each dish, its method of preparation, and groceries needed for it. This form is added to the notebook, and each patient may add for her own future use any recipes from it that appeal to her. Many of the national food companies have been most generous in supplying pamphlets on meal planning, food charts, and recipe booklets.

The Home Arts Section is housed in a rennovated older building on the center grounds, and includes a sewing, cutting and ironing area, a large dining area, and a double kitchen. The kitchen is equipped with new cabinets, stoves, refrigerators, and appliances. The entire home arts area is well furnished and creates a warm and cheerful homelike setting. Each patient in turn invites a guest of her choice to the meal prepared by the group and acts as hostess in this realistic social situation.

A two-hour period is planned once a week for taking a group of patients shopping at a nearby supermarket. This will give them opportunities to shop under supervision. The purpose of this activity is to help patients develop an interest in shopping, make decisions about purchases, manage money within a budget, and get acquainted or reacquainted with grocery items and prices.

Sewing classes are included in the home arts program and are held from 1 p.m. to 4 p.m. Other homemaking skills, such as washing, ironing, and time-management, will be taught either individually or in small groups.

THE DEVELOPMENT OF A PATIENT-PRODUCED PUPPET SHOW

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Occupational therapy for patients of the Adams County Team consists of small group activity. Four or five groups of ten to twelve patients choose their own projects, and the entire hospital community uses articles the team creates. Group paintings, ceramic-tile tables and plaques, picnic furniture, and rugs have been produced under this program. The occupational therapist serves as a resource person to all groups and offers suggestions and technical skills as they are needed.

Last spring the Adams Team was treating a hostile, hysterical patient who was very resistive to the treatment program. One day she said, "This joint is good enough for the movies!" Another patient, with theatrical background and training, took her comment seriously and began to talk about writing a play about the hospital. The staff picked up this lead, and team members and patients casually discussed the idea during the next several days. On hearing about it, the occupational therapist suggested that the team produce a puppet show during occupational therapy periods. This caught the fancy of both staff and patients, and patient representatives consulted two professional puppeteers.

Shortly afterward, all Adams Team occupational therapy groups started projects coordinated to the group goal of a puppet show. The woodworking group constructed a large stage. The ceramics group made puppet heads of papier-mache. The sewing

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**At the time the puppet show was produced, Dr. Selkin was staff psychologist on the Adams County Team.

group designed and made a curtain and puppet costumes, while the art group went to work on stage props and scenery. A patient committee guided all of these efforts and wrote the script for the play.

The story line of the play was humorous, describing a newly admitted patient, called Nosey, who came to the hospital seeking a magic pill to cure his depression and anxiety. The patients caricatured both the staff and themselves through the puppets. The team psychiatrist was given a donkey's head, and the psychologist emerged as "Smokey the Bear." The social worker was "Swinging Tom," a monkey. The speaking cast rehearsed the script repeatedly on tape and then added a musical score. The patients operated the puppets by hand and synchronized the action of the play to the tape. In a comic finale, to the stirring accompaniment of the "1812 Overture," Nosey found his magic pill--a laxative.

The team presented the puppet show to the staff and patients of Fort Logan Mental Health Center and to several other hospitals in the Denver area. Patient leaders in the project willingly accepted an invitation to appear on a local radio program.

In evaluating the puppet show project, the staff unanimously agreed that the most positive effect engendered among the patients was a spirit of group belonging and participation. The cooperative efforts between the playwrights and builders, and later among the puppeteers, tape recording operators, and prop men, promoted interaction and group goal-seeking. Some patients, who rejected treatment in the sense of verbal, psychotherapeutic intervention, actively participated in the show and made good use of the opportunity to appropriately express their negative feelings toward the hospital. One manic patient, who had refused any kind of treatment, was in great demand for the show because of his deep, strong voice. For the first time in a year of hospitalization, this patient took an active interest in group activity.

Complex projects such as the puppet show may have negative results. If the patient group is passively resistive, staff members may find themselves futiley pushing, then dragging the group, and ultimately having to do the project themselves. If this happens, the over-all experience is a failure for both patients and

staff. The staff must clearly communicate the patients' responsibility for the completion of projects, and at the same time be ready to help and support patient interaction. In the puppet show, for example, the patients appointed as codirector a domineering patient who hoarded the script. This disrupted group effort in the project, but although the other patients expressed their anger to a staff member, they were unable to deal with the uncooperative patient. In a patient meeting, the staff then supported the group's appropriate expression of their anger directly to the codirector, which resulted in the reestablishment of satisfactory working arrangements for the show.

Staff members felt that the puppet show was a successful project. They found themselves expending extra time and effort in supporting patient enthusiam for the project, serving as liaison between patient group and hospital administration, helping the patients to overcome osbtacles, and working with them in the routine activities the project required. However, they felt that the apparent therapeutic benefit to the patients involved justified the time and effort invested.

BOOK REVIEW

COMMUNITY AS DOCTOR: NEW PERSPECTIVES ON A THERAPEUTIC COMMUNITY. By *Robert N. Rapoport*, Springfield, Illinois. C. C. Thomas, 1960, pp. 325. $9.75.

In recent years community therapy has achieved some measure of popularity. The unqualified enthusiasm of some of its proponents should be tempered by Rapoport's scrutiny of Maxwell Jones' pioneer work at Belmont Hospital in England. Despite its shortcomings, this attempt to illuminate the processes, pitfalls, and advantages of a therapeutic community is a valuable study. The author, an anthropologist who spent four years at Belmont, was aided in his research by a group of experts in nursing, sociology, social work, and psychology.

Distinctive features of the community are *democratization* (each member of the community should share equally in the exercise of power in decision making about community affairs, both therapeutic and administrative); *permissiveness* (members should tolerate from one another a wide degree of behavior that might be distressing or seem deviant according to "ordinary" norms); *communalism* (freeing of communication through sharing of amenities and informality, e.g., use of first names); *reality confrontation* (patients should be continuously presented with interpretations of their behavior as it is seen by most others).

The norms of the community are in many instances different from those in the outside world. Thus incorporation of the ideas and values of the unit may lead to serious conflicts on return to the wider community. Indeed Rapoport's analysis of his follow-up data indicated that those patients who tended to change their values in the direction of the values of the hospital community showed less satisfactory adjustment upon discharge than those who did not.

The ideals of democracy, permissiveness, and so on, are abandoned, from time to time, whenever social disorganization occurs within the hospital. Then there is a temporary reinstitution

of authoritative leadership, intervention of hospital authorities, and discharge or commitment to a mental hospital of uncooperative, disruptive, or untreatable patients. Such periodic episodes of "collective disturbances" are not confined to therapeutic communities but have also been reported in conventional mental hospitals.

All members of the community are expected to attend group meetings and to express their feelings in these groups. Everyone is expected to "feed back" information about others and to participate in decision making. The doctor's role requires renunciation of much authority and a willingness to act as a coordinator of a team rather than as an individual psychotherapist. The physician must modify his ethical position on confidentiality of information and must give up much of the control of events in the psychiatric treatment situation while retaining full formal responsibility. Not all physicians are willing or able to accept this role.

Despite the efforts to establish barriers to individual doctor-patient relationships, Rapoport's studies showed that the patient who has the most positive attitude towards his own doctor improves more frequently than do those whose feelings center on other figures. A chapter on the role of the family in treatment and rehabilitation contains much useful information.

In the final chapter Rapoport lists thirty postulates regarding the organization of a therapeutic milieu. These postulates deserve careful study by all staff members who are responsible for administrative and treatment policies in psychiatric hospitals. Unfortunately, Rapoport's literary style is not pellucid and this handicap is most evident in the postulates. Surely, "Where harmonization, neutralization or disengagement of discrepant role directives are not possible, it is advisable to make explicit the effective limitations of the ideological prescriptions in the particular context," could be expressed more simply, if not epigrammatically.

One may question Rapoport's methodology, as Maxwell Jones does in his introduction to the book, but regardless of shortcomings, this is a very useful review of a most ambitious undertaking. Jones deserves commendation for selecting patients who for the most part suffer from severe character disorders. These patients pose a very difficult therapeutic challenge, and they have

been largely neglected by more conventional hospitals and therapists.

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CORRESPONDENCE

To the Editor:

I would like to offer one individual's reaction to the most interesting and challenging article by Dr. Sherman Nelson in the winter issue of the Journal of the Fort Logan Mental Health Center.

In my opinion, this is probably the most clearly written presentation of existential thought that I have ever encountered, and Dr. Nelson is certainly to be congratulated on this score.

Some questions arise, however, in my mind, for which I have no ready answers:

1. The existential attitude and therapeutic community focus on self-realization. I suppose that this means realization of one's most cherished objectives in life, as well as one's full potential. I believe that the realization of one's potential must be related, first of all, to the *existence* of such life objectives. What about the patient who has no such objectives? I am thinking here of the many psychopaths who view as their life objectives, perhaps the acquisition of a car or a home, if they care to look into the future at all. These people, at least on a conscious level, do not care about their past, *or* about their future, but live only from moment to moment for the immediate gratification of their impulses. How do they fit into this scheme?

2. Both the existential attitude and the therapeutic community seem to reflect the value system of our American society, namely, its emphasis on independence and self-sufficiency. Everybody working in the mental health or welfare field knows, however, that there are untold numbers of people who are unable to live up to this standard. What happens to such people in the therapeutic community? Do all of them improve in the direction of greater independence? Are there some who are made more aware of their shortcomings, cannot change and therefore are driven into depression and possibly suicide?

3. The author compares existential concepts with newer thought in ego psychology as advanced by Hartman and others. He undoubtedly refers to the secondary autonomy of the ego. He

seems to forget that in many forms of mental illness it is just this autonomous functioning of the ego which is most badly damaged so that the patient is at the mercy of largely unconscious conflicts and drives, and is in no position to make autonomous choices and decisions.

4. Finally, I would like to express my hope that in the current enthusiasm about the many benefits to be gained from a therapeutic community setting, basic insights, which it has taken many decades to attain, will not be forgotten or depreciated. There is, in my opinion, real danger that this might happen. In America we have an unfortunate habit of throwing out the old instead of building on it.

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Dr. Nelson replies in the letter which follows.

I appreciate Dr. Schapire's comments on my article and the thought provoking questions he has raised. I will reply to each of of his questions in turn, pointing out in advance that my answers are probably not the "ready" ones he mentions in his letter, as these are few and far between in the area of mental illness and its treatment.

1. Dr. Schapire states that the realization of one's potential must be related to the existence of life objectives. I assume that by this he means the conscious existence of life objectives which the individual can clearly express. The latter may be eminently desirable, and in my article I point out that more emphasis should be given to this area in the therapeutic-community setting. However, it is not an absolute necessity for self-realization. There are certainly many who are leading productive, fulfilled lives in their occupational, family, and community settings who would have a very hard time stating their life objectives in any but indeed the vaguest terms, if they were able to state them all at. The acquisition of a car or home for some, far from being psychopathic, may well demand and involve considerable self-realization in their

achievements, which an outside observer can understand and describe far better than the person engaged in the endeavor. There are many who live only from moment to moment for the immediate gratification of their impulses. Some of these people may be achieving a considerable degree of self-realization *if* they can bring about this gratification through the fullest use of their capacities, and without hurting or making excessive demands on others. There are, unfortunately, those whose moment-to-moment seeking of gratification involves pain and unhappiness for those with whom they interact. I doubt if this group can be said to be achieving their full potential, as one of the conditions of self-realization is social, and involves living harmoniously and helpfully with one's fellow man.

2. Dr. Schapire seems to imply that there is an *absolute* standard of independence and self-sufficiency in American society for all, which is reflected in the existential attitude and the therapeutic community. These qualities are relative and vary widely from person to person in terms of potential and capacity. Certainly some individuals are capable of achieving far more independence and responsibility than others. The existential attitude and the therapeutic community point up that many individuals can, with help, be brought to a far greater self-sufficiency than they were thought capable of by an older system of psychiatric thought which emphasized weaknesses rather than potentials. An extreme example would be the chronic lifelong schizophrenic who eventually is able to be placed in a supervised family-care home and who works several hours a day in a sheltered setting. Few would argue that this orientation is no more self-sufficient than a drugged stupor in front of a television set on a back ward. It is certainly true that not all patients in the therapeutic community attain greater independence. Yet the opportunity and the help needed in this struggle are made available. Some patients in the therapeutic-community setting do become depressed at a greater awareness of their shortcomings. This is common in almost all forms of therapy, individual, group, or therapeutic community. However, one of the major skills needed in treatment is to temper the bringing about of greater awareness with support and realistic planning toward the the optimal use of the strengths the patient possesses.

3. My very brief comparison of existential concepts with ego psychology was not meant to imply that the two systems of thought are interchangeable, as they certainly are not, but only to point up some basic similarities. The concept of the secondary autonomy of the ego, as elucidated by Hartman, was a pioneering contribution in the development of what has rather loosely come to be known as ego psychology. However, this concept can no longer be regarded as the whole of ego psychological theory, which is now characterized by a view of personality and treatment emphasizing present social reality and giving less emphasis to instinctual and historical factors. I certainly hope that I have not forgotten that a badly damaged ego may result in the patient being more prone to unconscious conflicts and drives and less able to make choices and decisions. I would point up, however, that few patients are completely unable at all times to take any degree of responsibility for themselves and that ego psychology has made a valuable contribution in its orientation on the strengths, rather than just the weaknesses, of even mentally ill egos. An attitude on the part of treating personnel which basically assumes complete helplessness on the patient's part because of largely or completely unconscious conflicts or drives is not calculated to allow the patient to demonstrate any of these strengths.

4. I am wholeheartedly in agreement with Dr. Schapire's concern that the therapeutic-community movement, like many new movements, may overreact against the past and ignore the wealth of knowledge which preceded it. Certainly one of the major problems in this form of treatment, which it is necessary to be fully aware of in each case, is that of helping the individual realize his fullest potential in and through the group setting, while at the same time avoiding the submergence of the individual in the group, which may become an end in itself. Training in the basic insights of the intrapsychic processes may, for example, help the therapeutic-community worker to maintain the most effective balance between the individual and the group in evaluation and treatment. In addition, an awareness of the contributions of earlier theories, techniques, and research to our information about the weaknesses and incapacities of the mentally ill individual may also enable

the therapeutic-community worker to assess and treat his patients realistically, without overemphasizing potentials which not all may be capable of fully realizing.

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NOTICE TO CONTRIBUTORS

The *Journal of the Fort Logan Mental Health Center* invites contributions in the areas of milieu therapy, social psychiatry, and related fields.

Manuscripts should be submitted in triplicate in the form in which the author wishes the paper to appear. Copy should be double-spaced, with margins of at least one and one-fourth inches.

References should be indicated by numbers in parentheses that refer to the list of references at the end of the article. The list should be alphabetical, and the names of the journals should not be abbreviated. The following format should be observed:

JAHODA, MARIE, Current Concepts of Positive Mental Health, New York, Basic Books, 1958.

RIESMAN, D., "Some Observations on Interviewing in a State Mental Hospital," Bulletin of the Menninger Clinic, Vol. 23, pp. 7-19, 1959.

The author should include an address to which inquiries regarding the article should be sent, in the form of a footnote indicated by an asterisk on the first page of the article.

Manuscripts should be addressed to Paul Polak, M.D., Editor, Journal of the Fort Logan Mental Health Center, Box 188, Fort Logan, Colorado. Reprints will be furnished at the author's expense.